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Recommendations for Some Medi-Cal Improvement

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THE MEDI-CAL part of the California State budget is often fair game for critics, and the potshots seem to recur with almost predictable periodicity. The criticisms reach a peak during the governor's and legislature's budget considerations and during the annual meeting of the California Medical Association. Both sources have recently, like volcanoes threatening to erupt, been sending out warning puffs of smoke. The puffs may or may not coalesce into a storm cloud with thunder and lightning, but they do tend to obscure basic facts and to impede constructive changes. Because the Medi-Cal program is so big, so complex and so important, and because all parties are basically altruistic but of different viewpoints, the whole issue can get overcharged with an electric tension. Unfortunately this may cause government on the one hand and the health professions on the other to appear in an adversary relationship, and progress suffers. Excessive dynamic tension in one person can cause catatonia; in a societal program so major as health services it may also paralyze action. And the society as surely as an individual person is suffering unnecessary hurt and pain.

The times now clearly call for bold measures in order to meet both fiscal needs and amount and quality of health services. Preparation for possible national health insurance also demands a new look at the basic goals of the Medi-Cal program and especially its administrative structures. If Medi-Cal were a patient, we would say it is basically sound but acutely ill and getting worse—and immediate, vigorous, but careful treatment is needed. The general approach of both the Reagan and Brown administrations has been small-scale palliative, not curative nor rehabilitative; both have tended to make fine adjustments in the components of the present system. What is needed is major and fundamental change in the system itself, maybe even radical

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surgical procedures. Even though the system is very large, very complex and very important, the challenge is clear and unavoidable. We should not be overwhelmed or fearful; we must be both creative and courageous.

The economic pressures on the governor, and in fact on all of government, are both great and real—and of course must be weighed. Those of us outside of government administration must also bear them in mind and try to be sympathetic to the problems faced by Governor Brown. But we should just as clearly let him know we are opposed to waste and inefficiency in the use of our monies. I would also hope and pray we let him know that we understand the folly of providing less than good quality health care to anyone; that is surely the greatest, the most costly waste of all. But the governor, like all citizens, is caught in the vise of recession and increasing demands for services, with the strong arm of inflation tightening the vise. However, lamentations do no good; only basic, specific and major changes will help.

First, an issue of critical importance must be resolved, and on that depends all else. Does California want a double standard of health care; does California want two parallel systems of personal health delivery? If the answer is yes, little action is needed; if the answer is no, there is much to be done. However, both the medical profession and government have traditionally rejected the double standard as bad medicine, as being penny wise and pound foolish. Since the opening paragraphs of Title XIX of the Social Security Act (Sect. 1902 [10] [A] [ii]) states that all United States citizens have an equal right to health care, we must again reject the discriminatory separate system for the aged, the poor, the disabled, the blind, the mentally ill, the mentally retarded, the medically indigent, the prisoners. The alternative stated in the law is that of strengthening the present private system of health delivery as the only way to guarantee the same quality and kind of services equally to all.

The primary purpose in making these suggestions for major change is to improve health benefits available to anyone in need. Second, I am convinced that the publicly funded sector of personal health services can be made more effective (greater patient benefits to cost ratio). And third, I believe that the profession of medicine can lead the way in developing new attitudes by government and about government. My background is probably unique in California in that I can speak from the viewpoint of several years in the private practice of medicine as well as several years of public executive management in health. While these views are entirely my own responsibility, perhaps they can be acceptable to both government and medicine—and serve as a starting point to debate and to progress.

In order to change cost-benefit ratios, one thinks first of raising or lowering one or the other, but I propose neither. Instead I propose a shift of monies from unnecessary or duplicative bureaucracy to the purchase of the full range of clinical services. The major way savings in the delivery system are to be found is in improved, streamlined administration and in expanded availability of quality clinical services. California already provides the most generous benefits of any state under its medical assistance plan, but a few specific benefits should be expanded (such as teeth and hearing aids for the elderly and home health services). In any event, benefits should not be reduced; so we are forced to look at the way in which administrative and some program monies should be shifted. In order to do this, obstructive administration must be recognized for what it is; it must be replaced with simplified but auditable procedures that neither prevent health services nor penalize providers.

Recommendations

I

The first suggestion, said succinctly, is: consolidate and computerize. A single contract between the State and a single fiscal intermediary should be developed at once. This intermediary would provide fully computerized data systems for the management of all monies now going into duplicative systems. These separate systems presently are Blue Cross-Blue Shield (the Blues), California Dental Services (CDS) and the state-operated Short-Doyle (S-D) system. They should all be merged into a single intermediary program. Also to be included in the new system would be eligibility data, sent directly from the county level to the intermediary. All institutional providers, including home health agencies, should also be included in the single fiscal intermediary operation.

The direct linkage between county and intermediary would permit many efficiencies such as (1) reduction of personnel in Department of Health; (2) far quicker acquisition and verification of eligibility information; (3) computer

scanning for duplicated cases; (4) elimination of the sticky label system of utilization control. This last efficiency will allow two major improvements, in addition to the other efficiencies: (a) remove a major source of provider dissatisfaction, and (b) be consistent with anticipated national health insurance legislation. Present law establishes the Professional Standards Review Organization (PSRO) system, which is more and more moving toward "front end" controls, that is, utilization review in advance of services. This was the intent of the proof of eligibility (POE) stickers and the treatment authorization request (TAR) systems—and while they were generally effective, they did create resistances and animosities. The system suggested here should have much better provider approval and still be consistent with present and future federal legislation.

Yet other major advantages of this suggestion are in purely administrative savings. The fiscal intermediary could verify many claims that are now returned to the provider for time consuming reprocessing. In fact, the entire claim form could be simplified, thereby reducing the work load of the provider and staff. Another major benefit would be the relative ease of providing costs per patient by category of patient (such as number of dollars spent per Aid to Dependent Children patient or blind patient). This would then allow for the first time cost figures based on known, verifiable and comparable experience to be used in both budget preparations and rate setting for Prepaid Health Plans (PHP's) or Health Maintenance Organizations (HMO's).

Parenthetically the PHP's have received excessive negative attention; even their detractors generally come around to endorsing their basic concept. In so doing the persistent pressure needed for change gets displaced from administrative flaws to generalities. The PHP's could be vastly improved if only one additional fact were recognized—the major defect of many publicly funded personal health programs. There is a time-honored dictum in the field of public health—the dollars and services must be relatively higher in areas of greater need. It seems self-evident that this must be so if the level of health in areas of need is to be brought up to standard. If this concept prevailed, a few simple administrative changes could be made to remove most if not all of the grounds for criticism. These are (1) pay enrollers like insurance salesmen—that is, the longer an enrollee stays in the plan, the greater percentage of the enrollment fee is paid; (2) allow physicians an enrollment fee but allow it to be justified as health counseling and education; (3) increase cost allowances for greater percentage of a provider's case load being Medi-Cal patients and especially for being medically indigent patients. (The second suggestion makes use of the most powerful manpower resource, and the third creates a fiscal incentive to care for the most ill.)

This whole system would make full use of cathode ray tube (CRT) remote stations, a system I have described for years as the "United Air Lines system," though all major air lines have similar abilities. United, America's largest, has one computer to handle *all* of its passenger reservations, each with a great many bits of information, some of it held for months at a time. Also they have one or more remote CRT's at every airport and ticket counter. If the airlines can do it nationwide and save or make money, why should not the State of California do the same and reap the same benefits?

It makes little sense from the State or taxpayer's point of view to have competing systems such as the Blues and CDS. The latter organization deserves to be separate from that of the physicians, but the State should not allow a parochial attitude to justify spending millions of tax dollars. It is true the CDS contract is highly significant as a prepaid plan, but this feature can be retained while having the mechanical fiscal disbursement done elsewhere with similar functions. Exactly the same logic can be applied to the S-D program, but there other changes will be needed and will be discussed below.

The dollars available from these changes, to be shunted into direct clinical services, would be between $30 and $40 million per year out of $141.6 million for administration for fiscal year 1975-1976. The reductions or elimination of many functions presently done by the Department of Health and the Department of Benefit Payments would allow the transfer of many employees to clinical functions within several State departments such as Health, Youth Authority, Corrections. It would also allow many trained employees to work in other much needed areas—beautification, water and air pollution control, public safety, reforestation, and the like. Within the Department of Health and the Department of Benefit Payments, there would need to be an upgrading of many positions so as to meet an increased need for clinical and fiscal audit teams.

II

The second change can also be succinct: Pay now; audit later. One of the most intense dissatisfactions with the Medi-Cal program from both individual persons and institutions is delay in payment of a claim. Since the majority of claims of individual providers are paid relatively promptly, the same should be done with all claims, whether from individual persons or institutions. Reconciliation of audits can only be done after the fact; so why not pay at once and get an earlier start on auditing? This would also solve many facilities' cash flow difficulties, a major problem. As it is now, many hospitals and other facilities must borrow money at high short-term interest rates (10 to 13 percent) against accounts receivable. This interest then gets added to costs which are passed on to all payers, including Medi-Cal. And worst of all, neither patient nor hospital gets any benefit from this passing on of costs, and the hospital must also add on the clerical cost of keeping track of the accounts, the loans and the interest. If claims were paid on presentation and Medi-Cal accounts receivable could not be used as collateral for borrowing, the State could reduce total program costs by as much as $48 million per year in interest savings alone.

This change allowing more money to be spent on clinical services would have little or no effect on personnel needs of State departments. The only effect would be on the lending companies. While that may be regrettable, the State must give first consideration to stretching its health dollars. But the pay-on-demand policy would keep many dollars circulating, thereby benefiting all segments of the business community.

The present intermediary operation (the Blues) has the capability of providing periodic computer printouts of all payments to any provider. These should be done routinely and should be designed to provide all data to make such reports useful for both income tax and national health insurance purposes. Each provider could easily be given a quarterly *itemized* listing of claims paid, making subsequent audits much easier than the present quarterly report of total payments. It would also be an easy and potentially advisable thing to have each patient sign each claim form before submission. This would educate patients as to costs and procedures done and would also serve as a receipt for services rendered.

III

In collaboration with appropriate professional associations, the State should define levels of care within acute general hospitals for which the State will pay. These levels should be defined in terms of personnel who render services to patients—for example, the number of hours of nursing care per patient per day. Nursing care would include all personnel of the nursing service who are necessary to provide patient care. Similarly the other professional services should be defined with patients in mind rather than from an administrative point of view. One of the most rapidly rising costs in the health industry has been hospital costs, and these increases have been mostly due to personnel costs. If hospital management costs are to be controlled, personnel needs must be defined and limited. While this suggestion has the greatest potential savings, it is the most difficult to quantify. If actual savings cannot be realized, at least maintaining the level of costs for inpatient services in general hospitals is not too much to expect. It would move in the direction of determining institutional payments on the same basis as outpatient payments—that is, what was done directly on behalf of the patient.

IV

The State should abandon its discriminatory practices against health professions; follow the federal law in Title XIX and pay usual, customary and reasonable (UCR) medical charges. This would of course increase the expenditures in all areas of professional services, but it would make the medical system an economically honest system. It would make for much greater reliability of projections since they could be tied more closely to widely used indices. In this way forecasting and budgeting would be much more open and public, as well as reliable. As an example, physicians now are being paid at about 62 percent of what usual and customary fees were in 1968, but the determination of this schedule has not in the past been done publicly.

Pharmacists are similarly penalized by the same attitude toward costs. They are also hurt by the slowness of the State to ascertain wholesale costs on which are based allowable charges per prescription. Other professionals are similarly expected to accept cut-rate fees; home health services may be the object of the greatest discrimina-

tion. To the extent that this is true, it is wasteful of money, health and manpower—and is a particular hardship for the elderly.

In general the savings in dollars alone from the suggestions so far would *not* be immediately equal to the increases needed if UCR were adopted. But the State would benefit in a way more valuable and derive greater long-range benefits in two ways. First is the openly direct administrative system referred to above, and second is the single health delivery system. The double standard is far too costly in the long run because it allows, if not encourages, the most expensive category of patient—the medically indigent. Experience has shown these patients to have the least eligibility and an average cost per illness several times that of the person with greater eligibility. It is health poverty that drives costs up, and given time, our double standard approach will break our medical-dollar bank more surely than spending money for good treatment for all.

My last suggestion may be the most surprising but is most consistent with advocacy of eliminating the double standard: Phase out and eliminate Short-Doyle (S-D) in favor of the private systems. It should not be surprising, however, in view of the fact that many counties have for years relied partly on private practitioners as individual practitioners or as groups. Los Angeles County led the way, followed by Marin County and finally by many Valley counties that contract with the Kingsview complex. The Kingsview group has done an excellent job of providing a full range of services at reasonable costs and has at the same time been quickly responsive to counties' emerging needs for services. I would propose that all direct clinical services be transferred to the private sector and the indirect or educational consultative services be transferred to county health or education departments.

The assumption of all patient treatment services by the private sector would create new patterns of care. These would probably include: (1) Many patients would be followed through their mental disorder by their primary care physician; (2) mental health specialists would do more consultations with primary physicians; (3) specialists would employ more, or work more closely with, ancillary personnel such as social workers or psychologists or both; (4) private hospitals and day centers could expand; (5) new guidelines for independent professional activities by psychologists and social workers would need to be drawn up; (6) more outpatient group work would be done; (7) State hospitals would be more useful as back-up to the private sector and would be in much closer touch with the private sector; (8) only bona fide mental illness would be treated.

The benefits to the State are both clinical and fiscal—better treatment, or at least as good, and monetary savings. The dollar savings would come from the shift to fee for service, thus providing strongly positive motivation to actually treat patients. The improved treatment services would highlight the areas of failure of the present S-D system (such as for children and the aged). The S-D system has evolved into one dealing mostly with emancipated minors and young adults, and while many of them do need treatment, the needs of children and the elderly are more acute, and the S-D system was originally designed to give the elderly comprehensive care, including mental health care. The shift to the private sector would allow all ages to receive benefits more nearly according to need. It is most regrettable that despite the promises of many Social Security and health programs over the past forty years, the elderly are still badly underserved.

The abolition of S-D would eliminate the largest societal expression of the double standard in health. Is California ready for this kind of change? I would say it is—with certain understandings and with certain conditions applied. Virtually all mental health professionals are trained in hospitals and so know how to handle patients who need inpatient care; also psychoactive drugs have revolutionized psychiatric treatment. Control and sometimes cure of mental disorder is now possible, and public danger can be reduced. Because danger cannot be eliminated, however, the private sector must have easy access to security inpatient facilities.

If reasonable controls were imposed on mental health services in the private sector, savings could amount to one quarter of the current budget for nonhospital services, or about $60 million per year. These controls would include treatment only for diagnosable mental disorder (that is, no psychiatric treatment would be included for persons only disabled by physical disease or by educational, social or vocational handicap). For many mental health diagnoses, profiles would be developed, and treatment outside of such norms could easily be audited by clinical teams, as has been done for physical disorders. Individual provider profiles

would also be more extensively developed. Both kinds of profiles are being required by federal law to be done by PSRO's.

Discussion

How would such bold suggestions be implemented; what would the costs be; and most importantly, what would be the long-range benefits? Implementation could be done by combined executive-legislative action, but any such changes are bound to founder on opposition from public and professions alike unless there is much open discussion. Goal-oriented, time-limited and broad-based membership of gubernatorially appointed task forces would reduce these problems and give the State valuable input from both providers and consumers. It appears that both government and medicine are in communication already, but the public must also be brought in. The costs of initiating the changes recommended here would be negative (that is, there would be savings, but these should be shifted over to purchase of the full range of clinical services).

In order to know better how to spend the monies, it would help to see where they have come from and the changes year by year. Careful examination of Table 1 shows these changes, and especially the pronounced rate of growth of State government administration (the data in this table are from governors' annual budgets). The table also clearly shows how very much the professional services have failed to keep up with increase in either program costs or administration. Even when one takes only the last five years (1970 through 1975) so as to make allowance for start-up costs, the trends are the same. Another reason for comparing data before and after 1971 is that the Medi-Cal Reform Plan was begun on October 1, 1971. No matter how the data are examined, administrative or government costs are rising much the fastest, and professional services are rising the slowest. It is no wonder, then, that professionals (physicians, dentists, pharmacists, home health specialists) are crying foul. As if that were not enough, Governor Brown's first budget has recommended an increase in professional services of only 1.7 percent in the face of a projected inflation of 12.2 percent—but an 8.5 percent increase in nonprofessional salaries for State workers.

One of the unfortunate and probably undesired effects of the present out-of-balance budgeting is the creation of the double standard system —one for the poor and one for the average or well-to-do. In 1971-1972, while I was still Director of Health, it was common though quiet knowledge that only 64 percent of all practicing physicians were satisfied with their participation in the Medi-Cal program. Because the number was even then trending down and because of uncorrected dissatisfactions, I am sure that figure is now about 55 percent and in another year will be about 35 percent. Unless changes similar to those presented here are put into effect, the number of available professionals will continue to dwindle; they feel as if they are being subjected to double taxation—direct taxes and subventing the Medi-Cal program. Both the system and the health of the poor must be saved and saved now. There is no imperative more calculated to pay large long-range dividends. The changes advised here will reverse these manpower trends and return us to a

TABLE 1.—*Changes from Year to Year in State Costs Related to Medi-Cal*

	Annual Inflation Rate (percent)*	*California Medi-Cal Total Program (millions†)*	*California Medi-Cal Population (millions)*	*California Government Administrative Costs (millions†)*	*California Professional Services (millions‡)*
1966-67	2.7	$ 507.5	1.2982	$ 21.0	$143.3
1967-68	4.3	563.4	1.4757	28.1	145.4
1968-69	5.5	754.8	1.6436	36.6	186.0
1969-70	6.0	869.3	1.8569	36.4	212.0
1970-71	4.4	1,039.9	2.3777	60.3	260.7
1971-72	3.0	1,551.9	2.4126	75.1	284.6
1972-73	5.7	1,575.1	2.3139	97.5	329.4
1973-74	11.5	1,628.9	2.2396	125.6	396.6
1974-75§	15.0	2,042.1	2.4152	122.3	423.0
1975-76§	12.2	2,261.8	2.6297	141.6	430.3
Percent increase 1966-76		364	103	574	200
Percent increase 1970-76		118	10.6	135	65

*Bureau of Labor Statistics, nationwide.
†Includes federal, state and county monies.
‡Medical and dental services.
§Estimated.

single standard system, a costly system, but one much less costly than the one toward which we are heading. The various professional associations should, if necessary to prevent the creation of the double standard system and in order to protect the rights of the poor, join together and bring suit, forcing the State of California to obey the federal law. The professions must recognize such suits are system directed, not personally directed, and can be carried forward in a style and manner entirely respectful to both government and medicine. The professions should after all be the leaders in bringing about the best health for the most people, and that is the single standard system.

The most fundamental changes needed and recommended are ones of attitude: Government and medicine must trust each other to deal fairly and openly with each other and must actually do so. Both professions are in fact about 95 percent honest; the 5 percent can easily be identified and removed. In medicine and especially the Medi-Cal program that winnowing should be very easily done with computerized physician and disease profile data and active clinical audit teams. These latter functions can in the near future be taken over by the PSRO's and/or county medical societies or dental societies. With the medical profession being mostly honest and dishonesty easily controlled, the legislature and the governor should find it easy to supervise the contract with a single fiscal intermediary, to simplify accounting and managerial procedures and to put more money where it will produce more direct patient benefit. By the same token, the medical profession must recognize politicians really want to do what is best for all the people, but medicine must present hard data to back up its positions.

Most of all, the medical profession must recognize that the conservative approach is probably best in the consulting room but should be abandoned in the social-political area. Instead we should exercise our creativity in these areas and prove our imaginative and constructive capabilities. In this way government and medicine together should strive not to build complex systems with multiple denigrating checks and balances. What should be built is a single, simplified, auditable, inexpensive administrative system good for patients, providers and public alike.

The principles I am advocating are all to be found in a true story about a young, ambitious junior executive with the mail order division of a large retail store. When he noticed two complaints in a week from customers who paid for bicycles but did not receive them, he devised a systems analysis protocol. When he presented his proposal to an executive staff meeting, the conversation between him and the vice-president went like this:

V.P.: "How much will your analysis cost?"
Jr. Exec.: "$60,000."
V.P.: "How many complaints in a year do we get?"
Jr. Exec.: "Two or three."
V.P.: "How much does a bicycle cost us?"
Jr. Exec.: "$38."
V.P.: "After this, when anyone complains that they haven't received their bicycle, send them a bicycle."

Neither this story nor these suggestions contain all the wisdom or changes to make a perfect Medi-Cal system. There are undoubtedly many other refinements and improvements that could be developed and tested with good results. It was only my intent to show the order of magnitude of the approach needed and most of all the new attitudes needed.

Summary

Major changes in the Medi-Cal Program (in California the Title XIX or MedicAid Program) are needed now. They should include simplification, unification and computerization of many administrative functions, especially fiscal disbursement. The system should be made honest and law-abiding by adopting usual, customary and reasonable fee schedules, but furnishing each provider a quarterly itemized report of payments made. This report would have both audit and income tax benefits and usefulness. The changes recommended would generate about $150,000,000 in fiscal year 1975-1976 that should be shifted to purchase of clinical health services. The changes will require much cooperation among government, medicine and the general public. Professional organizations are urged to give serious consideration to joining forces in a suit against the State to force compliance with federal laws.